STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 04537

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
MARY	ANDERSON	BRENT	FEBRUARY 15, 1974	9:10 P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
FEMALE	WHITE	3 / 31 / 86	87 YRS.	1 / 17	

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	UNITED STATES		KENT COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CHESTERTOWN	KENT & QUEEN ANNE'S HOSPITAL	HOUSEWIFE	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	KENT	ROCK HALL	YES ☐ NO ☒	———

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
WILLIAM	EDWARD	AYRES	GEORGIA		HERSCH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		213-12-1698	HOSPITAL RECORDS - CHESTERTOWN, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CHF	
DUE TO, OR AS A CONSEQUENCE OF (b)	ASCVD	
DUE TO, OR AS A CONSEQUENCE OF (c)		

4124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from FEB. 15, 19 74, to 2/15/74, 19 ____, that (I) ~~(we)~~ last saw the deceased alive on FEB. 15, 19 74, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Robert Damm		

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. ROBERT DAMM M.D.	HIGH STREET, CHESTERTOWN, MD 21620

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	2-18-74	WESLEY CHAPEL CEM.	ROCK HALL	KENT	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
HELFENBEIN-HUBBARD SEC. TO LANE FUN. HOME	CHURCH HILL MD.	FEB 20 1974	Lindsay M. Norton

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 60M 1/73
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 04538

1. DECEASED NAME (TYPE OR PRINT) FIRST: Elijah	MIDDLE: Washington	LAST: Elbourn	2a. DATE OF DEATH MONTH: February	DAY: 2,	YEAR: 1974	2b. HOUR: 12:05 A M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH: Aug. DAY: 21, YEAR: 1900	6. AGE (IN YEARS LAST BIRTHDAY): ~~Sex~~ 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Kent MD.			
10. CITY OR TOWN OF DEATH: Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Kent & Queen Anne's	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): waterman	12b. KIND OF BUSINESS OR INDUSTRY: food			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Kent	Rock Hall	YES ☒ NO ☐	none

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Joseph	Leonard	Elbourn	Harriet	Elizabeth	Beck

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		219-05-4591	K & Q/A Hosp. Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4109 IMMEDIATE CAUSE (a) Myocardial infarct — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan 30, 19 74, to Feb. 2, 19 74, that (I) (we) last saw the deceased alive on Feb. 2 19 74, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
A.C. Dick M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-4-74

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
A.C. Dick, M.D.	Chestertown, Md. 21620

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
burial	2-4-74	wesley Chapel Cem.	Rock Hall Kent Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE RECD. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Helfenbein, Hubbard sec. Lane Fun. Home	Church Hill Md.	FEB 7 1974	Sidney H. Norton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH-16 60M 1/73
(VR A 15 (4))

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 60M 1 73
(VR A 15 (4))

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 04539

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR		
WALLACE	HERMAN	FORD	FEBRUARY 25, 1974	11:50 P M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	
MALE	WHITE	12/25/89	84 YRS.	10		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND	UNITED STATES		KENT MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY			
CHESTERTOWN	KENT & QUEEN ANNE'S HOSPITAL	RET. TAX ASSESSOR	COUNTY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
MARYLAND	KENT	BETTERTON	YES ☒ NO ☐	—		
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST	
EDWARD	W.	FORD	KATE	?	SMITH	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
NO	—	216-18-2991	HOSPITAL RECORDS-- CHESTERTOWN, MD 21620			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Carcinomatosis	1 year
DUE TO, OR AS A CONSEQUENCE OF (b)	Adenocarcinoma of Cecum	2 years
DUE TO, OR AS A CONSEQUENCE OF (c)		

1530

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
2-6-74	Exploratory Laparotomy (mass in cecum)	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from JANUARY 29, 19 74 to FEBRUARY 25, 19 74, that (I) (we) last saw the deceased alive on FEBRUARY 25, 19 74, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED
A.C. Dick, M.D.			2-26-74
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.C. DICK, M.D. ~~DR. ROBERT DAMM M.D.~~		22e. ADDRESS HIGH STREET, CHESTERTOWN, MD 21620	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
BURIAL	2-28-74	STILL POND CEMTY	STILL POND KENT MD.	
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
VICTOR N. KENNEDY	STILL POND, MD.	MAR 01 1974	Virginia Norton	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 04540

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: CHARLES	MIDDLE: HENRY	LAST: HOLLEY	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 26, 1974
			2b. HOUR: 1:00 A M
3. SEX: ~~Male~~ MALE	4. RACE: NEGRO	5. DATE OF BIRTH MONTH DAY YEAR: 1/2/02	6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: KENT MD.
10. CITY OR TOWN OF DEATH: CHESTERTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): KENT & QUEEN ANNE HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED (?)	12b. KIND OF BUSINESS OR INDUSTRY: Work

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	KENT	CHESTERTOWN	YES ☒ NO ☐	115 RAILROAD AVE

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
LEWIS	?	HOLLEY	JOSEPHINE	?	MITCHELL

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	—	083-01-3751	HOSPITAL RECORDS-CHESTERTOWN, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CHF.
DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD.
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that ~~I~~ (this hospital) attended the deceased from FEB. 25, 19 74, to FEB. 26, 19 74, that (I) (we) last saw the deceased alive on FEB. 26, 19 74, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Robert LaDamm		

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. ROBERT DAMM M.D.	HIGH STREET, CHESTERTOWN, MD 21620

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	3/2/1974	JANES CEM.	R.F.D. CHESTERTOWN KENT Md

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Kenneth Wilson CHESTERTOWN, MD	MAR 7 1974	Sidney M. Horton

BP

DHMH - 16 60M 7/73
(VR A 15 (4))

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04541

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 must be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S) 8M-1/70

1. DECEASED-NAME (Type or Print) First: Thomas	Middle:	Last: Hopkins	2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ] Month: Feb. Day: 3 Year: 19 74	2b. HOUR 7:45 M		
3. SEX: Male	4. RACE: Colored	5. DATE OF BIRTH: JUNE 11, 1968	6. AGE (In years last birthday): 5 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month: Feb. Day: 5 Year: 19 74	2d. HOUR 7:45 M	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Kent Md.			
10. CITY OR TOWN OF DEATH: R.F.D.#2 Rock Hall	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): At Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): NONE	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Kent	13c. CITY OR TOWN: Rock Hall	13d. INSIDE CITY LIMITS? YES [ ] NO [+]	13e. STREET AND NUMBER: R.F.D.#2		
14. FATHER'S NAME First: Rudolph	Middle:	Last: Hopkins	15. MOTHER'S MAIDEN NAME First: Lorraine	Middle:	Last: Laster	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: None	17. INFORMANT: Rudolph Hopkins	ADDRESS: Rock Hall, Md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Probable severe burns, smoke, fumes and
DUE TO, OR AS A CONSEQUENCE OF: CO inhalation
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 890X
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]
21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. 2/3 19 74	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.): House fire
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): House	21f. LOCATION Street or R.F.D. No.: Rock Hall; City or Town: Kent; County: Maryland; State: Maryland

22a. **I certify** that I taak charge of the remains described abave, held an Autopsy [ ], Inspectian [X], Inquiry [ ], and in my apinian death resulted from: Natural couses [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Robert W. Farr M.D.

EXAMINER'S NAME (Type): Robert W. Farr M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: 2/5/74

ADDRESS (Street, city, town, or county): Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Feb. 6, 1974	23c. NAME OF CEMETERY OR CREMATORY: Aaron Chaple Cem.	23d. LOCATION (City or Town): R.F.D. Rock Hall (County): Kent (State): Md.	
24. FUNERAL DIRECTOR: [signature]	ADDRESS: Chestertown, Md.	25a. REC'D BY REGISTRAR DATE: FEB 13 1974	25b. REGISTRAR'S SIGNATURE: [signature]	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO. 04542

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR		
ELSTON	ELWOOD	KENDALL	FEBRUARY 21, 1974	6:00	A M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	
MALE	WHITE	5/16/05	68 YRS	2 / 7		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND	UNITED STATES		KENT COUNTY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY			
CHESTERTOWN	KENT & QUEEN ANNE'S HOSPITAL	FARM MANAGER	AGRICULTURE			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
MARYLAND	QUEEN ANNE	CENTREVILLE	YES [ ] NO [X]	ROUTE # 3		
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST	
ELWOOD	?	KENDALL	DAISY	?	SAUL	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
NO		217-36-0474	HOSPITAL RECORDS-CHESTERTOWN, MD			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Shock	5 hrs.
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (b)	Anterior myocardial infarction	12 hrs.
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Possible renal infarction.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [X] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from FEB. 15, 19 74, to FEB. 21 19 74, that (I) (we) last saw the deceased alive on FEB. 21, 19 74, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED
Thomas Solon	M.D		2-26-74
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
DR. THOMAS SOLON M.D.	CHESTERTOWN, MD 21620		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
BURIAL	2-24-74	STILL POND CEMTY	STILL POND KENT MD.	
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
VICTOR N. KENNEDY	STILL POND, MD.	FEB 28 1974	Sidney [illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH-16 60M 1/73
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 04543

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
LUCINDA	ELIZABETH	LANE	FEBRUARY 21, 1974	12:40P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
FEMALE	WHITE	10/9/02	71 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
MD.	USA		KENT MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CHESTERTOWN	KENT & QUEEN ANNE'S HOSPITAL, INC.	HOUSEWIFE	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	QUEEN ANNE	CHURCH HILL	YES [X] NO [ ]	CHURCH HILL, MD. 21623

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
FREDERICK		ROE	BESSIE		Jackson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		215-12-6705	HOSPITAL RECORDS, CHESTERTOWN, MD. 21620

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Emphysema
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD. CHF
DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD

4124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from FEB. 20, 19 74, to FEB 21, 19 74, that (I) (we) last saw the deceased alive on FEB. 21, 19 74, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR [X] / STAFF PHYSICIAN	22c. DATE SIGNED
Edward L. Damm		2/22/74

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
R.L. DAMM, M.D.	CHESTERTOWN, MD. 21620

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
burial	02-24-74	Woodlawn Cemetery	Easton Talbot Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Helfenbein-Hubbard Sec. To Lane Funeral Home	Church Hill Md.	FEB 26 1974	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-1660M 1/73
(VR A 15 (4))

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04544

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print): First: Charles; Middle: Henry; Last: Laster Jr.

2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ]: Month Day Year: Feb. 3 1974

2b. HOUR: 7:45 A M

3. SEX: Male

4. RACE: Colored

5. DATE OF BIRTH: Mar. 23, 1964

6. AGE (In years last birthday): 9 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.

2c. DATE PRONOUNCED DEAD: Month Feb Day 3 Year 1974

2d. HOUR: 7:45 A M

7a. BIRTHPLACE (State or foreign country): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: Kent Md.

10. CITY OR TOWN OF DEATH: R.F.D.#2 Rock Hall

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): At Home

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): School

12b. KIND OF BUSINESS OR INDUSTRY: Student

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland

13b. COUNTY: Kent

13c. CITY OR TOWN: Rock Hall

13d. INSIDE CITY LIMITS? YES [ ] NO [+]

13e. STREET AND NUMBER: R.F.D.#2

14. FATHER'S NAME: First Charles; Middle Henry; Last Laster Sr

15. MOTHER'S MAIDEN NAME: First Reba; Middle; Last Wickes

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16b. SOCIAL SECURITY NO.: None

17. INFORMANT: Charles H. Laster ADDRESS: Rock Hall, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Probable severe burns, smoke, fumes &
DUE TO, OR AS A CONSEQUENCE OF: CO inhalation
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.: 5-6 2-3 1974

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): House fire

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): House

21f. LOCATION Street or R.F.D. No.: Rock Hall City or Town: County: Kent State: Md.

22a. **I certify** that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Robert Farr M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type): Robert W. Farr M.D.

ADDRESS (Street, city, town, or county): Chestertown, Md.

22b. DATE SIGNED: 2-5-74

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Feb. 6, 1974

23c. NAME OF CEMETERY OR CREMATORY: Aaron Chapple Cem.

23d. LOCATION (City or Town) (County) (State): R.F.D. Rock Hall Kent Md.

24. FUNERAL DIRECTOR: Bernard Day ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: FEB 13 1974

25b. REGISTRAR'S SIGNATURE: Virginia K. Waters

VR A15ME (5) 8M-1/70

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 04545

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Reba; MIDDLE:; LAST: Laster

2a. DATE OF DEATH — KNOWN [X] ESTIMATED [ ] — MONTH: 2 DAY: 3 YEAR: 19 74

2b. HOUR OF DEATH: 7:45 A.M.

3. SEX: Female

4. RACE: Negro

5. DATE OF BIRTH — MONTH DAY YEAR: Feb. 23, 1947

6. AGE (IN YEARS LAST BIRTHDAY): 26 YRS.

IF UNDER 1 YR. — MONTHS: DAYS:

IF UNDER 24 HRS. — HOURS: MIN.:

2c. DATE PRONOUNCED DEAD — MONTH: 2 DAY: 3 YEAR: 19 74

2d. HOUR PRONOUNCED DEAD: 7:45 A.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Kent County MD.

10. CITY OR TOWN OF DEATH: Chestertown

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): ~~Walley Funeral~~ Home near Rock Hall, Md

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Labor

12b. KIND OF BUSINESS OR INDUSTRY: various

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Kent

13c. CITY OR TOWN: Rock Hall

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: R.F.D. # 2

14. FATHER'S NAME — FIRST: Henry; MIDDLE:; LAST: Wickes

15. MOTHER'S MAIDEN NAME — FIRST: Edna; MIDDLE:; LAST: Chambers

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 220-52-0023

17. INFORMANT — ADDRESS: Charles Laster Sr. Rock Hall, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Burns and acute carbon monoxide intoxication

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate couse (a) stating the underlying cause last.

890x

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?:

20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY — HOUR A.M. MONTH DAY YEAR: 5-6 ~~xx~~ 2 3 19 74

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): house fire

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): house

21f. LOCATION — STREET: CITY OR TOWN: Rock Hall COUNTY: Kent STATE: Md.

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: W. S. Medart Jr. M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 2-4-74

EXAMINER'S NAME (TYPE OR PRINT): William S. Medart, Jr., M.D. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 6, 1974

23c. NAME OF CEMETERY OR CREMATORY: Aaron Chaple Cem.

23d. LOCATION — CITY OR TOWN: R.F.D. Rock Hall COUNTY: Kent STATE: Md.

24. FUNERAL DIRECTOR — NAME: [signature] ADDRESS: Chestertown, Md.

25a. DATE REC'D. BY REGISTRAR: FEB 13 1974

25b. REGISTRAR'S SIGNATURE: [signature]

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, LEAVE ITEMS 22a AND 22b UNEXECUTED AND EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

1

FOR STATE HEALTH DEPT.

M

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Parts 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 8M-1/70

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04546

1. DECEASED-NAME (Type or Print)	First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED	Month	Day	Year	2b. HOUR			
	Steven	Anthony	Laster	☑	Feb.	3	1974	7:45	M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
Male	Colored	April 3 1969	4 YRS.					Feb	3	1974	7:45 M
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH								
Maryland	USA		Kent Md.								
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY								
R.F.D.#2 Rock Hall	At Home	None									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER							
Maryland	Kent	Rock Hall	YES ☐ NO ☒	R.F.D.#2							
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last				
Charles	Henry	Laster Sr.		Reba			Wickes				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS							
No		None	Charles H. Laster	Rock Hall, Md.							

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Probable severe burns, smoke, fumes &

890x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CO inhalation

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)
5 -	6 2 / 3 / 1974	House fire

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	House	Rock Hall	Kent	Maryland	

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE _____ M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED 2/5/74

EXAMINER'S NAME (Type) Robert W. Farr M.D.

ADDRESS (Street, city, town, or county) Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Feb. 6, 1974	Aaron Chaple Cem	R.F.D. Rock Hall Kent Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
	Chestertown, Md.	FEB 13 1974	Sidney H. Norton

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO. 04547

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT): FIRST GEORGE; MIDDLE WILLIAM; LAST McGUIRE
2a. DATE OF DEATH: MONTH FEBRUARY; DAY 20; YEAR 1974
2b. HOUR: 9:30 A M
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: MONTH DAY YEAR 3/21/04
6. AGE (IN YEARS LAST BIRTHDAY): 70 69 YRS. IF UNDER 1 YEAR: MONTHS 1 DAYS 1; IF UNDER 24 HRS.: HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: KENT COUNTY MD.
10. CITY OR TOWN OF DEATH: CHESTERTOWN, 62
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): KENT & QUEEN ANNE'S HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): FARMER Ret.
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND 14
13b. COUNTY: KENT
13c. CITY OR TOWN: MASSEY
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS: BOX # 7

14. FATHER'S NAME: FIRST WILLIAM; MIDDLE THOMAS; LAST McGUIRE 1
15. MOTHER'S MAIDEN NAME: FIRST EMMA; MIDDLE NMN; LAST CAIN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES): —
16b. SOCIAL SECURITY NO.: 214-32-2001
17. INFORMANT ADDRESS: HOSPITAL RECORDS - CHESTERTOWN, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myelofibrosis v Myeloid Splenic Metaplasia.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 209x
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: 2.11.74 2
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Hypersplenism
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from FEB. 7, 19 74, to FEB. 20, 19 74, that (I) (we) last saw the deceased alive on FEB. 20, 19 74, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 2.26.74
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. ARTHUR KEEFE M.D. 1
22e. ADDRESS: MEDICAL BLDG., CHESTERTOWN, MD 21620

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2/23/74
23c. NAME OF CEMETERY OR CREMATORY: Galena Cemetery
23d. LOCATION CITY OR TOWN: Galena; COUNTY: Kent; STATE: Md.

24. FUNERAL DIRECTOR NAME AND ADDRESS: Edward Fellows & Son, Millington, Md. 21651
25a. DATE REC'D BY REGISTRAR: FEB 26 1974
25b. REGISTRAR'S SIGNATURE: [signature]

DHMH 16 60M 1 73
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 04548

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 60M 1/73
(VR A 15 (4))

1. DECEASED NAME (TYPE OR PRINT) FIRST: CASPER	MIDDLE: NMN	LAST: MEREDITH	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 16/74
2b. HOUR: 7:45 P.			
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: 9/2/96	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS.
IF UNDER 1 YEAR MONTHS: 6	DAYS: 13	IF UNDER 24 HRS HOURS	MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: KENT COUNTY MD.
10. CITY OR TOWN OF DEATH: CHESTERTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): KENT & QUEEN ANNE'S HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): FARMER	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: QUEEN ANNE	13c. CITY OR TOWN: SUDLERSVILLE	13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS: ROUTE # 1			
14. FATHER'S NAME FIRST: JAMES	MIDDLE: EDWIN	LAST: MEREDITH	15. MOTHER'S MAIDEN NAME FIRST: SMITH,
MIDDLE: MARTHA	LAST: JANE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): WW-I	16b. SOCIAL SECURITY NO.: 218-20-7202	17. INFORMANT ADDRESS: Mrs. Mildred Meredith (wife) HOSPITAL RECORDS - CHESTERTOWN, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma of Liver — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 mos.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1978

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: 1.24.74	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Biopsy of Liver.	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1.7.74 19____ to 2.16.74 19____, that (I) (we) last saw the deceased alive on 2.16.74 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 1.18.74

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. ARTHUR KEEFE M.D. — 22e. ADDRESS: MEDICAL BUILDING, CHESTERTOWN, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial	23b. DATE: 2-19-74	23c. NAME OF CEMETERY OR CREMATORY: Church Hill Cem.	23d. LOCATION CITY OR TOWN: Church Hill COUNTY: Queen Anne's Co. STATE: Md.
24. FUNERAL DIRECTOR NAME AND ADDRESS: Helfenbein-Hubbard Sec. To Lane Funeral Home, Church Hill Md. 21623	25a. DATE REC'D. BY REGISTRAR: FEB - 6 1974	25b. REGISTRAR'S SIGNATURE: Sidney [illegible]	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04549

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR
Clarence	Hollie	Phillips	February 22 1974	1P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
Male	White	June 3, 1890	83 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Md.	USA		Kent Co. Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Chestertown	Magnolia Hall Nur. Home	carpenter	retired

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Kent	Galena	YES ☒ NO ☐	unk.

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Edward		Phillips	Sallie	Clara	Twilley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	213-16-7891A	Mr. Andrew Phillips Taylors Island

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Hypopituitarism** — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2531
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port I or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 2/1, 19 74, to 2/22, 19 74, that (I) (we) last saw the deceased alive on 2/22 19 74, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Robert M Farr	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	2/22/74

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Robert W. Farr, M.D.	Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
burial	Feb 24 '74	Dorchester Mem.Pk.	Cambridge Dor. Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Thomas Funeral Home Box 348 Cambridge, Md.	FEB 26 1974	Sidney L Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 04550

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 1 of this should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST	CAROLINE PASQUAY PRATT
2a. DATE OF DEATH MONTH DAY YEAR	Feb. 13 1974
2b. HOUR	12:15 A M
3. SEX	female
4. RACE	white
5. DATE OF BIRTH MONTH DAY YEAR	Oct. 31, 1877
6. AGE (IN YEARS LAST BIRTHDAY)	96 YRS.
IF UNDER 1 YEAR MONTHS DAYS	
IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Balto. City
7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Kent County MD.
10. CITY OR TOWN OF DEATH	Chestertown
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Magnolia Hall Nursing Home
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Housewife
12b. KIND OF BUSINESS OR INDUSTRY	Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.
13b. COUNTY	Kent
13c. CITY OR TOWN	Chestertown
13d. INSIDE CITY LIMITS? YES ☐ NO ☐	
13e. STREET ADDRESS	
14. FATHER'S NAME FIRST MIDDLE LAST	Joseph Pasquay
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	Rose Snyder
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	no
16b. SOCIAL SECURITY NO.	217 48 7071
17. INFORMANT ADDRESS	J Mary Corr daughter Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4124
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/10 19 68 to 2/13 19 74, that (I) (we) last saw the deceased alive on 2/13 19 74, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED 2/13/74
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr	22e. ADDRESS Chestertown, Md. 21620	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2-15-74	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	23d. LOCATION CITY OR TOWN Pikesville	COUNTY Md. STATE
24. FUNERAL DIRECTOR NAME John Burns Sons	ADDRESS Towson Md.	25a. DATE REC'D. BY REGISTRAR FEB 19 1974	25b. REGISTRAR'S SIGNATURE Sidney [illegible] Norton	

DHMH-1660M 1-73
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 04551

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST	CLARA PEACOCK ROBINSON
2a. DATE OF DEATH MONTH DAY YEAR	Feb. 4, 1974
2b. HOUR	10:30 P M
3. SEX	female
4. RACE	white
5. DATE OF BIRTH MONTH DAY YEAR	Aug. 27, 1881
6. AGE (IN YEARS LAST BIRTHDAY)	92 YRS.
IF UNDER 1 YEAR MONTHS DAYS	
IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Chester, Pa.
7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Kent Co. MD.
10. CITY OR TOWN OF DEATH	Chestertown
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Magnolia Hall Nursing Home
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Housewife
12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.
13b. COUNTY	Kent
13c. CITY OR TOWN	Chestertown
13d. INSIDE CITY LIMITS? YES ☐ NO ☒	
13e. STREET ADDRESS	Baker's Lane RFD
14. FATHER'S NAME FIRST MIDDLE LAST	Samuel A. Peacock
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	Georganna Bramble
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	no
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	220 34 9208D
17. INFORMANT ADDRESS	Walter P. Robinson Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Arteriosclerotic cardiovascular disease	Several years
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 5/19 19 73, to 2/4 19 74, that (I) (we) last saw the deceased alive on 2/4 19 74, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

22b. SIGNATURE Robert W. Farr DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED 2/5/74

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr, M.D.

22e. ADDRESS Chestertown, Md. 21620

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	2/7/74	Crumpton Cemetery	Crumpton, Md.

24. FUNERAL DIRECTOR NAME J. Willis Wells ADDRESS Chestertown, Md. J. Willis Wells

25a. DATE REC'D. BY REGISTRAR FEB 7 1974

25b. REGISTRAR'S SIGNATURE Sidney P. Watkins

DHMH-16 60M 1-73
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO. 04552

1. DECEASED NAME (TYPE OR PRINT) FIRST: Raymond	MIDDLE: Edward	LAST: Stanford	2a. DATE OF DEATH MONTH DAY YEAR: February 4, 1974	2b. HOUR: 10:25A.M.	
3. SEX: Male	4. RACE: Negro	5. DATE OF BIRTH MONTH DAY YEAR: February 15, 1911	6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Kent		MD.
10. CITY OR TOWN OF DEATH: Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Kent & Queen Anne's Hospital, Inc.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Construction Work	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Queen Anne	13c. CITY OR TOWN: Sudlersville	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: Route# 1	
14. FATHER'S NAME FIRST: William	MIDDLE: E	LAST: Stanford	15. MOTHER'S MAIDEN NAME FIRST: Grace	MIDDLE:	LAST: Thomas
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO.: 214-12-6997	17. INFORMANT	ADDRESS: Hospital Records, Chestertown, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Feb. 4, 19 74, to Feb. 4, 19 74, that (I) (we) last saw the deceased alive on Feb. 4, 1974, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert E. Lee Clemmer — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ — 22c. DATE SIGNED: 2/7/74

22d. PHYSICIAN'S NAME (TYPE OR PRINT): R. L. Damm, M.D. — 22e. ADDRESS: Chestertown, Md.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2/9/1974	23c. NAME OF CEMETERY OR CREMATORY: ROOSEVELT CEM.	23d. LOCATION CITY OR TOWN: Church Hill	COUNTY: Q.A	STATE: Md
24. FUNERAL DIRECTOR NAME: [illegible]	ADDRESS: CHESTERTOWN, Md.	25a. DATE REC'D. BY REGISTRAR: FEB 13 1974	25b. REGISTRAR'S SIGNATURE: Sidney [illegible]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH-16 60M 1/73
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 04553

1. DECEASED NAME (TYPE OR PRINT) FIRST: Helen	MIDDLE: Fisher Brooks	LAST: Vincent	2a. DATE OF DEATH MONTH DAY YEAR: February 1, 1974	2b. HOUR: 3:45 A M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: July 7, 1915	6. AGE (IN YEARS LAST BIRTHDAY): 58 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Kent		MD.
10. CITY OR TOWN OF DEATH: Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Kent & Queen Anne's Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): R.N.	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Kent	Chestertown	YES XX NO ☐	115 Pine St.

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
James	Byxxd	Brooks	Agnes	Dugan	Fisher

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		213-33-7234	Kent & Queen Anne's Hosp. Records Chestertown, Md. 21620

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Metastatic Carcinoma	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (b)	Carcinoma of breast	
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan. 30, 19 74, to Feb. 1, 19 74, that (I) (we) last saw the deceased alive on Feb. 1, 19 74, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Robert W. Farr	ATTENDING PHYSICIAN XX MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/4/74

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Robert W. Farr, M.D.	Chestertown, Md. 21620

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/4/74	Chester Cemetery	Chestertown, Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
J. Wells Wells	Chestertown, Md.	FEB 5 1974	Lindsay H. Norton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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